posterior part of the urethra should be found. If the posterior end is not readily found, a suprapubic cystotomy should be performed and then by a retrograde catheterism the end found and the urethrotomy completed.

3. In case of a lesion of the posterior urethra he performs an external perineal urethrotomy with the aid of a staff. Cystotomy and retrograde catheterism are indicated in certain cases, as of traumatic origin, as in fracture of the pelvis.

In *résumé*, he says: 1. Hypogastric puncture is an excellent device; but it is expectant treatment to be used in emergency. It is without effect upon the lesion which is responsible for the retention.

2. Suprapubic cystotomy is a palliative and, at the same time, a curative measure. It is indicated in cases of infected prostatitis where there are false passages, and in cases where repeated catheterism has not re-established the urethra. It is the first step in many operations upon the posterior urethra. It is the second step in certain operations on the anterior urethra.

Iodides in the Thyroid Gland.—WEISS (*Münch. med. Woch.*, January 5, 1897) comments upon the richness in iodides of the glands of the inhabitants of Breslau, as shown by the researches conducted in the clinic of Prof. Ponfick. The amount of iodide was determined in the thyroid glands of adults who died from various causes, in persons suffering from goitre who died from an intercurrent disease, and in infants.

In fifty adults who died from sixty to seventy-seven years of age the desiccated thyroid weighed, on the average, 7 gr. 2, and contained 4 mgr. 0.04 of iodide. The average weight of the thyroid gland of the inhabitants of Silesia is, therefore, less than that of the inhabitants of Berlin (7 gr. 4), and of Freiburg (8 gr. 2), and greater than that of the inhabitants of Hamburg (4 gr. 6.) On the contrary, the average amount of iodide contained in the thyroid glands of the inhabitants of Breslau is greater than that of the inhabitants of Hamburg (3 mgr. 83) and of Freiburg (2 mgr. 5) and less than that of the inhabitants of Berlin (6 mgr. 6).

In the case of patients suffering from goitre the amount varied according to whether the patient had or had not been treated previously with the iodides. In those, to the number of nine, who had not been treated by the iodides, there were found traces, in two cases, and quantities varying from 6 to 11 mgr. In eleven cases treated by the iodides the amount found was from 12 to 18 mgr. In children under seven years the amount varied from traces to 0 mgr. 0.07 to 0 mgr. 0.78.

Congenital Fibro-papilloma of the Sole of the Foot.—DUIET (*La Méd. mod.*, November 4, 1896) reported the following interesting and rare case to the French Surgical Society: the patient, a boy, fifteen years of age, had a congenital tumor on the sole of his foot, which was painless, and of the thickness of four or five fingers; it occupied the entire sole of the foot and extended up on the sides and toes. It was traversed by deep furrows. The veins of the leg and thigh were exceedingly varicose, and were as large as one's thumb, and had the appearance of a cirsoid aneurism. The neoplasm made its appearance in the patient's third year, as small white elevations, hard, and the size of a pin's head in the centre of the foot.

Extirpation seemed impossible on account of the tenderness of the scar and the attending contractions. The author decided to remove it by abrasion. He employed a histological section-knife, after having removed the greater part of the tumor in small pieces with strong scissors. At the end of a few weeks fresh healthy granulations sprung up, and he succeeded in covering them by Thiersch's method of skin-grafting, and the patient is now able to walk, two years since the operation, without any pain or injury to the surface, and without recurrrence.

The Causation of Chloroform Syncope.—After a careful and comprehensive study, HILL (*British Medical Journal*, April 17, 1897) comes to the following conclusions:

1. Chloroform produces a primary failure of the circulating mechanism and a secondary failure of the respiratory centre. The respiratory centre fails to act not only because it is damaged by the drug, but because of the anæmia of the spinal bulb produced by the fall of arterial tension. This is proved by the fact that the action of the respiratory centre can be renewed by raising the arterial tension. The depth of anæsthesia depends, as does the paralysis of the respiratory centre, on the primary fall of the arterial tension.

2. Chloroform, more than any other known agent, rapidly abolishes the vascular mechanisms which compensate for the hydrostatic effect of gravity.

3. Chloroform abolishes these mechanisms by paralyzing the splanchnic vasomotor tone and by weakening the action of the respiratory pump. When these mechanisms are totally abolished the circulation is impossible if the subject be in the feet-down position.

4. Chloroform also produces paralytic dilatation of the heart. It acts directly like amyl nitrite on the musculature of the whole vascular system.

5. There are two forms of chloroform syncope: (*a*) during primary anæsthetization. The patient struggles, holds his breath, raises the intrathoracic pressure, congests his venous system, lowers his arterial tension, and finally takes deep inspirations and surcharges his lungs with chloroform. In the first stage the left heart becomes impoverished; in the second stage it is suddenly filled with blood. This is drawn from the lungs, and is full of chloroform. The chloroform passes into the coronary arteries, and the heart is thrown into paralytic dilatation. Respiration and the pulse either cease simultaneously or the pulse before respiration. (*b*) During prolonged anæsthetization this arises from gradually giving chloroform to too great an extent. The arterial pressure falls lower and lower, and, secondarily, the respiration ceases because of the anæmia of the spinal bulb. The heart is not in this case paralyzed by chloroform, because the drug is taken in gradually by the shallow respirations and distributed slowly by the feeble circulation.

6. Artificial respiration and the assumption of the horizontal position, if applied in time, will always resuscitate a patient from the second form of syncope.

7. Artificial respiration, established with the patient in the horizontal position, is also the treatment indicated in the first form of syncope; the heart should be rhythmically compressed by squeezing the thorax. If this does

not quickly lower the pulse, the patient should be put into the vertical, feet-down posture. The dilated right heart is thereby completely and easily emptied of blood. Artificial respiration is maintained during this manœuvre, and the patient is brought once more into the horizontal posture. By rhythmic compression of the chest an efficient circulation is maintained through the coronary arteries; by first emptying and then filling the heart a fresh supply of blood is brought into that organ. If this does not prove successful on the first trial, it can be repeated.

8. Inversion—that is, placing the subject in the feet-up position or compression of the abdomen—will increase the paralytic dilatation of the heart. In this kind of syncope both these forms of treatment are worse than useless.

9. In the condition of shock or emotional fear the compensatory mechanism for the effect of gravity is almost abolished, and chloroform may easily be the last straw to completely paralyze the circulation.

10. Vagus inhibition of the heart is of no importance as an agent in the production of chloroform syncope.

11. Ether is in every respect a far safer anæsthetic than chloroform. According to Binger's experiments on the heart, ether is fifty times less dangerous than chloroform.

12. With the practical conclusion of the Hyderabad Commission, that the chloroform inhaler should be removed during the struggling of the patient or when the respiration is of irregular depth, I am in absolute agreement; but I consider their interpretation of their own experiments and tracings concerning the origin of chloroform syncope to be mistaken.

Not only the work of all physiologists, but also the tracings of the commission, when rightly interpreted, prove that paralysis of the circulatory mechanisms, and not of the respiratory centre, is to be dreaded by the anæsthetist.

Uretero-pyelo-neostomy.—Among the tendencies of modern surgery the true conservatism of the aseptic and antiseptic era is the most marked of all advances.

BAZY (*Revue de Chirurgie*, May 10, 1897) draws particular attention to this fact in connection with operations on the kidney, in which, instead of performing nephrectomy, the attempt should be made in many cases to preserve the kidney in all its functional activity, illustrating the fact that if it is a great surgical feat to remove a viscus or a portion of the viscera it is a greater scientific achievement to preserve it and restore its function.

He reports two cases in which there was a large hydronephrosis. In the first he was enabled to re-establish a communication between the pelvis of the kidney and the bladder by resecting the ureter and implanting the distal portion into the most dependent portion of the dilated pelvis. This was accomplished in the following manner: Through a median laparotomy the tumor was reached, the fluid withdrawn by an aspirator, and the pelvis of the kidney incised. The orifice of the ureter was found far up on one side. It had been flattened out by the pressure of the pelvis and occluded in this manner. A fine catheter was passed through it nearly or into the bladder. The ureter was then resected. One side was cut open for a little way to enlarge the entrance and procure a larger surface to implant into the pelvis. An opening was made in the most dependent portion of the pelvis. A soft catheter, from which the tip had been removed, was passed a short distance into the ureter, while the other end passed out of the abdominal wound and gave, through an opening situated in the catheter within the pelvis of the kidney, exit to the urine in both directions. Drainage being provided in this manner, the ureter was stitched to the pelvic wall by interrupted catgut sutures, while a Lembert suture of silk was placed externally, care being taken not to penetrate the mucous surface so that the silk would come in contact with the urine. The wound in the pelvis of the kidney was stitched to the abdominal parietes, which were then closed by the ordinary layers of interrupted catgut and silkworm-gut sutures. The patient made a slow but complete recovery, the urinary fistula closed, and the complete function of the ureter was restored.

The second case was one of single kidney of the bi-lobar form. Nephrectomy was impossible, and, although the patient's condition was very poor, the attempt was made to restore the ureter. The kidney was, however, the seat of an infection, and the patient succumbed to a general infection, although the ureter was readily found, the operation performed, and the flow of urine re-established into the bladder.

Wire Hooks for Holding Open the Edges of Abscesses.—As a substitute for gauze tampons or drainage-tubes, BRAATZ (*Centralblatt für Chirurgie*, 1897, No. 16) recommends the employment of retractors formed of wire, which he finds hold the lips of the wound open more certainly and give better drainage than either gauze or rubber tubes, both of which are compressed by the edges of the wound, so that they do not fulfil the purpose for which they were employed.

These retractors are made of different sizes, and are held apart by a band of wire which passes from one to the other. They may also be made in spiral form for deep drainage, or gauze and rubber drainage-tubes may be employed at the same time, being inserted between the retractors. The author has employed them in numerous cases with gratifying results.

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF

J. SOLIS-COHEN, M.D.,

OF PHILADELPHIA.

The Progress of Laryngology and Rhinology.—DR. ST. CLAIR THOMSON, of London (from the Diamond Jubilee Commemoration number of the *British Medical Journal*, June 19, 1897), presents a succinct summary of the progress of laryngology and rhinology in the sixty years of the Victorian age, which is adorned with the reproduction of a signed photograph of

Manuel Garcia, the still living distinguished nonagenarian singing master of London, whose use of the dental mirror, for the purpose of studying the mechanism of voice, gave, in 1854, the initial impulse to laryngology of the present day.

Hard Fibroma of the Maxillary Sinus, with Pyæmia of the Frontal Sinus.—DR. L. J. HAMMOND reports (*Phila. Polyclinic*, August 7, 1897) this interesting case, which is illustrated with instructive wood-cuts. An Irishman, aged thirty-eight years, laborer in a chemical works, suffered violent pain in the left side of his face and forehead, which had resisted all manner of treatment—even the removal of his teeth on the left side of the upper jaw. There was a suppurative discharge from the left nostril and from the site of the second bicuspid tooth. The cartilaginous septum was gone, the loss attributed to the handling of vitriols. The pain was found to be largely due to pressure upon the dental and infra-orbital nerves by a growth in the maxillary sinus. This was removed after access to the parts from the exterior. An additional operation was necessary to trephine and drain the frontal sinus, and an incision was selected over the promontory roof of the nose and continued far enough to allow the flap to expose the inner edge of the superciliary ridge, at which point the sinus was trephined. The treatment gave complete relief, which had been permanent up to the date of the report. The record of this case is exceedingly instructive in its details.

Paralysis of the Larynx in Typhoid Fever.—M. BENOUD (*Lyon Médical*, March 28, 1897; *Boston Medical and Surgical Journal*, April 29, 1897) recently reported to the Lyon Society of Medical Sciences a case of paralysis of the posterior crico-arytenoid muscles occurring in the course of typhoid fever, which came on during the third week of the disease and was followed subsequently by paralysis of the soft palate. It is stated that in a recent monograph by Bouley and Mendel seventeen cases of paralysis in typhoid fever are reported, in six of which the posterior crico-arytenoid muscles were involved.

The Causes of Paralysis of the Recurrents.—M. LERMOYEZ (*Revue Internationale de Rhinologie, Otologie, et Laryngologie*, August, 1897) recently read an admirable and elaborate paper upon this subject before the French Society of Otology, Rhinology, and Laryngology, which we would commend to the careful study of those who have access to the original article, but which is too extensive even for an abstract in these columns.

In concluding his report three principal types of paralysis of the recurrents were presented for discussion:

First, incurable grave paralysis leading to death in consequence of the lesions which have produced it.

Second, incurable benignant paralysis, the cause of which often escapes us, but which is ordinarily simply an infirmity compatible with a prolonged life.

Third, curable and benignant paralysis, in which recovery takes place without any trace of its existence, and which seems to be but the result of a primitive neuritis, of which catching cold is one of the factors.